SECTION ONE:
Missouri Incident Fatalities

"A simple child,
That lightly draws its breath,
And feels its life in every limb,
What should it know of death?"

- William Woodsworth

In reviewing this report, the reader should be aware of some important definitions and details about how child deaths are reported and certified in Missouri, summarized here: (Please refer to Appendix 6, Definitions of Important Terms and Variables, for additional information.)

- **"Missouri Child Fatalities"** refers to all children age 17 and under, who died in Missouri, without regard to the state of residence or the state in which the illness or injury occurred. (For example, a child who is a resident of Kentucky, injured in a motor vehicle crash in Illinois and brought to a Missouri hospital, where he or she subsequently dies, would be counted as a "Missouri Child Fatality." This death would be reported to the Child Fatality Review Program on a Data Form 1, Section A, as an out-of-state event.)

- **"Missouri Incident Fatality"** refers to a *fatal injury, event or illness,* which occurs *within the state of Missouri.* (This is not necessarily the county or state in which the child resided.) If the death meets the criteria for panel review, it is reviewed in the county in which the *fatal injury, event or illness* occurred.

- *Every* Missouri incident child fatality is required to be reviewed by the coroner or medical examiner and the chairperson for the county Child Fatality Review Panel. The findings of that review are reported on the Data Form 1.

- Any child death that is *unclear, unexplained, or of a suspicious circumstance, and all sudden, unexplained deaths of infants one week to one year of age* are required to be reviewed by a county-based Child Fatality Review Panel. Panel findings are reported on the Data Form 2. Panel members receive annual training on the investigation of child deaths.

- **Multiple-Cause Deaths:** *Cause of death* is a disease, abnormality, injury or poisoning that contributed directly or indirectly to death. However, a death often results from the combined effect of two or more conditions. Because the Child Fatality Review Program is focused on the prevention of child fatalities, the precipitating events are of particular concern. Therefore, deaths are categorized according to the *circumstances of the death,* which may not be the immediate cause of death listed on the death certificate. (An example would be a child passenger in a car that runs off the road and lands in ditch full of water; the "immediate cause of death" is listed on the death certificate as "drowning," but the precipitating event was a motor vehicle accident. This death would be reported in the Motor Vehicle Fatalities section, with a footnote indicating that the death certificate lists "drowning" as the immediate cause of death.)

- The Child Fatality Review Program data management unit links data collected on the Data Forms 1 and 2 with Department of Health and Senior Services birth and death data. Every attempt is made to reconcile the two systems; however, in some cases, crucial data components are incomplete and are noted, as appropriate.

- All deaths included in this 2001 CFRP Annual Report occurred in calendar year 2001. Some of the cases reviewed may not have been brought before a county panel until the year 2002.

- In some cases, panels did not complete all of the information requested on the data form.

- Of the 481 Missouri Incident Fatalities reported on a Data Form 1 in 2001, 29 did not receive required CFRP panel review or panel findings were not submitted on a Data Form 2. It should be noted, however, that 17 of these (59%) were motor vehicle fatalities; a policy change including all motor vehicle fatalities as criteria for review took effect in 2001. These 29 fatalities are included in this 2001 CFRP Annual Report because the data, though incomplete, is useful and accurate within the limitations of the Data Form 1 information.

- In 2001, 42 Missouri Incident Fatalities were not reported on either a Data Form 1 or Data Form 2, but were reported to CFRP by death certificates from the Department of Health and Senior Services and other data sources. Eighteen of these 42 fatalities (43%) had at least one indication for review. These fatalities are not included in the data for this annual report.

Summary of Findings, Missouri Incident Fatalities, 2001

In 2001, **1146** children age 17 and under died in Missouri. Of those deaths, **1032** were determined to be "Missouri incident fatalities" and, therefore, subject to review by the coroner or medical examiner. Of the 1032 deaths, **481** had an indication for review by a county Child Fatality Review Panel and of those **452** were reviewed and a Data Form 2 completed.

Figure 1. Missouri Child Fatalities vs. Missouri Incident Fatalities

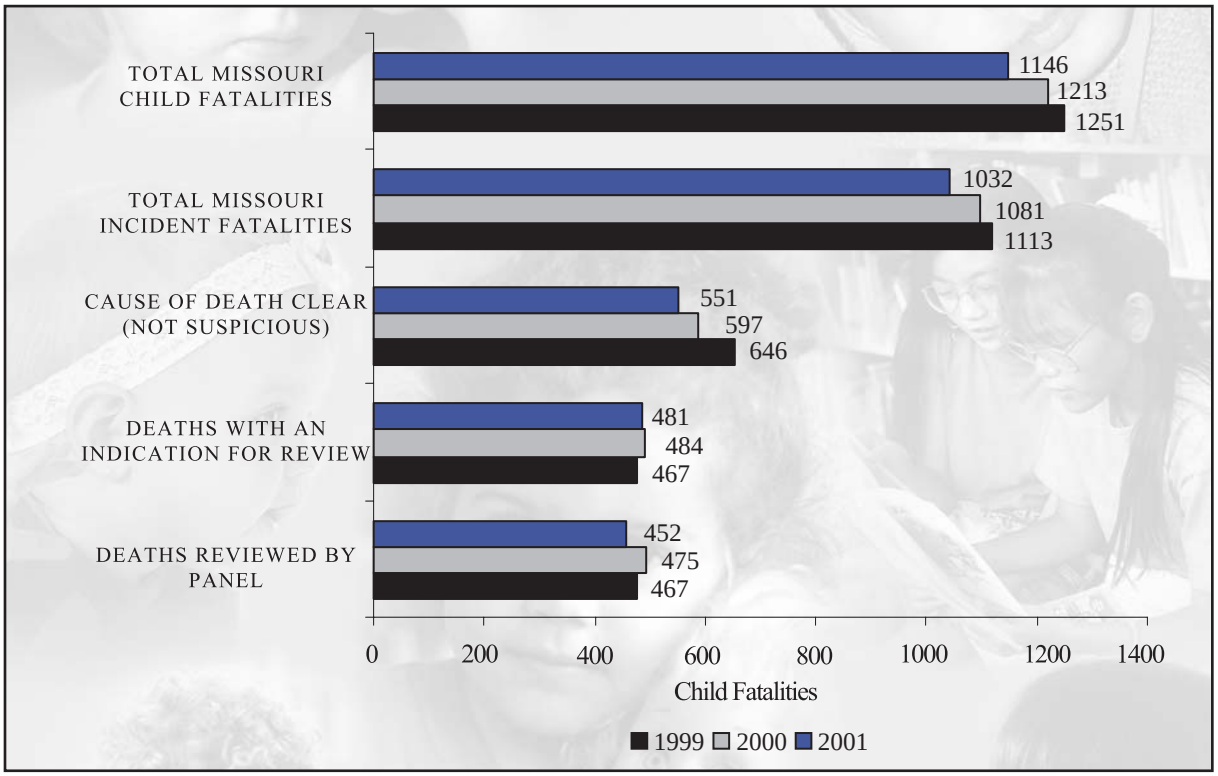
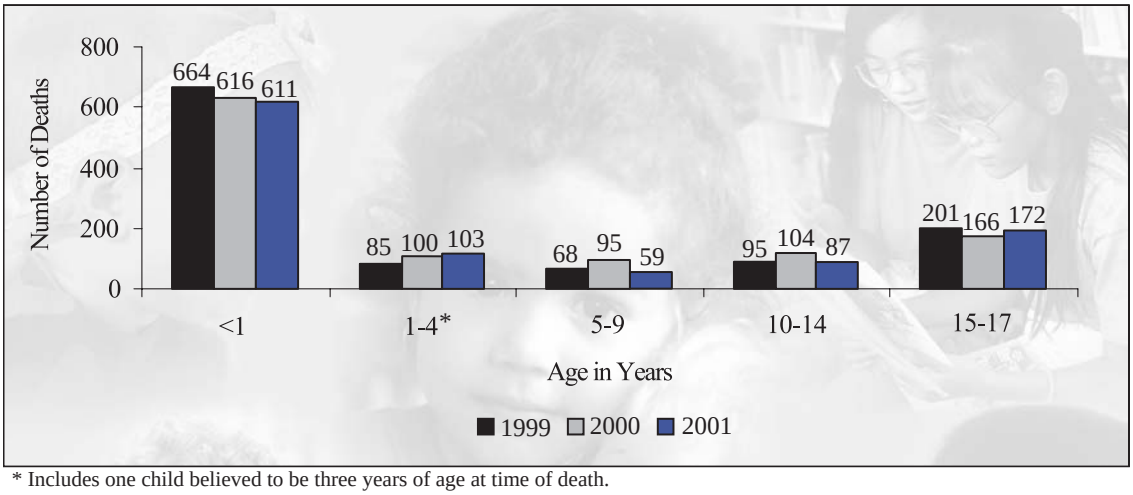


Figure 2. Missouri Incident Fatalities by Age



* Includes one child believed to be three years of age at time of death.

Figure 3. Missouri Incident Fatalities by Sex and Race

Sex	1999	2000	2001
Female	440	463	421
Male	673	618	611
	1,113	1,081	1,032

Race	1999	2000	2001
White	770	787	706
Black	328	284	310
Other	15	10	16
	1,113	1,081	1,032

Figure 4. Missouri Incident Fatalities by Manner

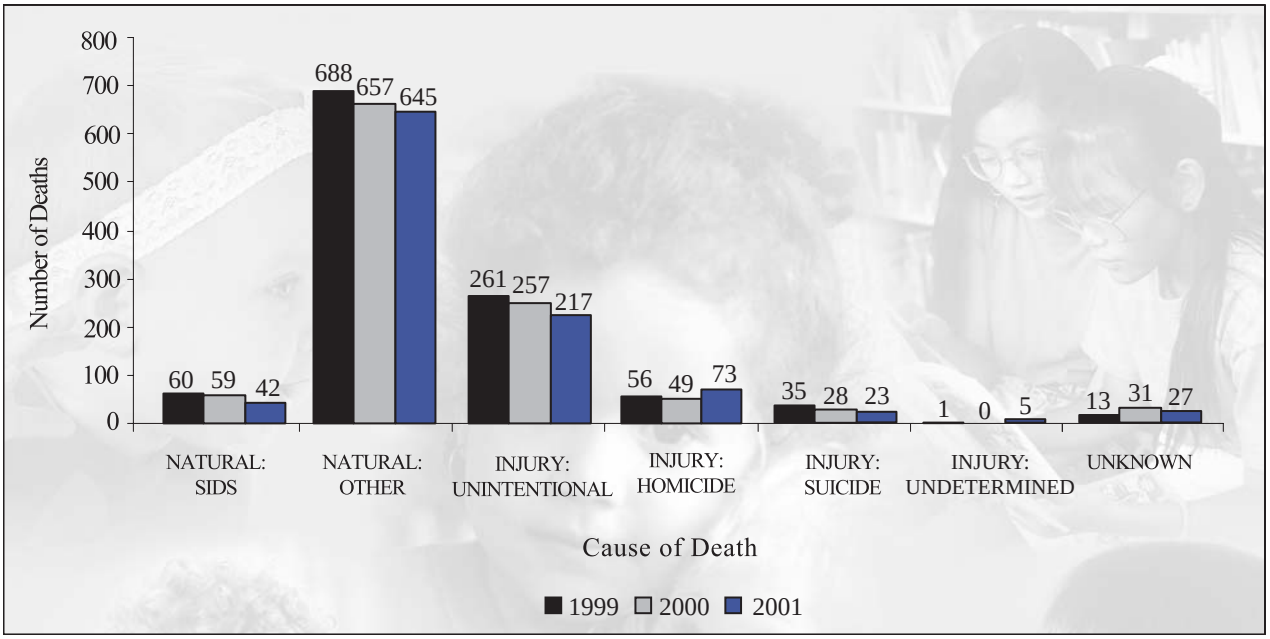
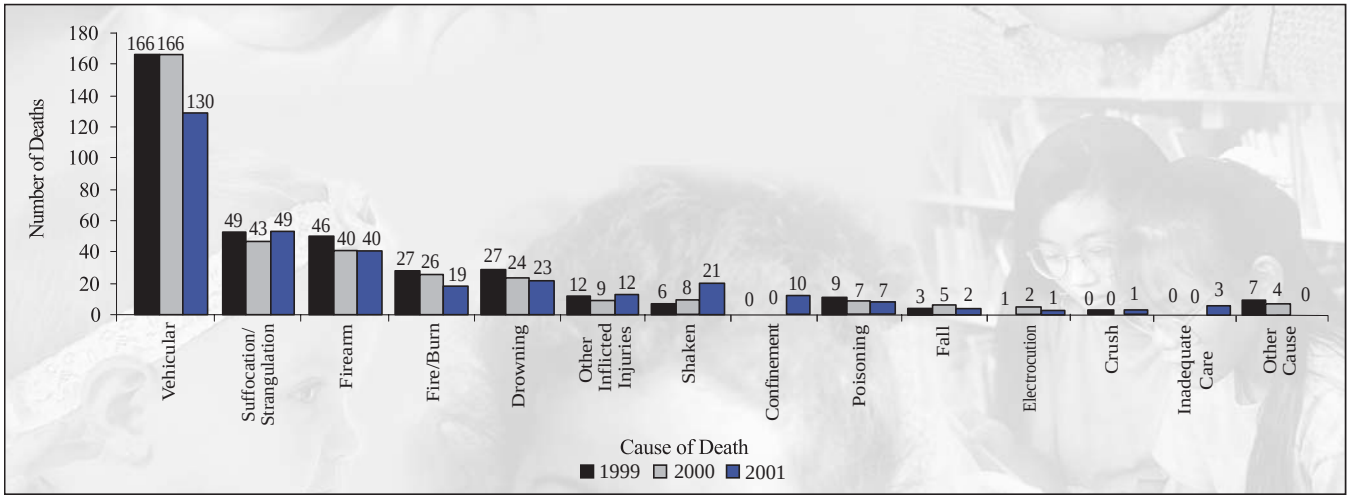


Figure 5. Leading Cause of Injury Deaths



Prevention Findings: The Final Report

"Injury is a problem that can be diminished considerably if adequate attention and support are directed to it. Exciting opportunities to understand and prevent injuries and to reduce their effects are at hand. The alternative is the continued loss of health and life to predictable, preventable and modifiable injuries."

-Dr. William Foege, Former Director of the Centers for Disease Control

The difference between a fatal and nonfatal event is often only a few feet, a few inches, or a few seconds. In the past, most people believed that serious and fatal injuries were random or unavoidable events, or simply the result of individual carelessness. Fortunately, the science of injury prevention has moved away from this fatalistic approach to one that focuses on the environment and products used by the public, as well as individual behavior. Injuries are now widely recognized as understandable, predictable and preventable.

A *preventable child death* is defined as one in which awareness or education by an individual or the community may have changed the circumstances that lead to the death. Prior to August of 2000, CFRP panels were asked to report their conclusions and prevention responses for each death reviewed on the Data Form 2. Legislation passed in 2000 now requires that the panel complete a Final Report, summarizing their findings in terms of circumstances, prevention messages, and community-based prevention initiatives.

The death of a child is a sentinel event that captures the attention of the community, creates a sense of urgency and a window of opportunity to respond to the question, "What can we do?" County-based prevention activities serve to raise awareness, educate parents and caretakers, influence public policy and involve the community in prevention initiatives that protect and improve the lives of children. In 2001, CFRP panels throughout our state reported their findings and prevention responses utilizing The Final Report. The initiatives highlighted below demonstrate how a few volunteer professionals have been able to measurably reduce or eliminate threats to the lives and well being of countless Missouri children.

Legislation, Law or Ordinance:

A 6-year-old girl died in a rural northwestern town trailer fire that was started by grease left unattended on the stove. The trailer did not have smoke alarms and the fire blocked the only available exit. The local CFRP panel requested that the trailer parks pass an ordinance to require working smoke detectors in all trailers. The panel also released several fire prevention tips in the local newspaper.

An 11-year-old boy was killed in a jet ski collision. Statutes require watercraft operators to be 14-year-olds. The county CFRP panel suggested that the statutes should be posted at the lake, docks and entrances and that safety training be provided before children are allowed to operate jet skis. The panel also encouraged the Water Patrol to strictly enforce these rules.

A 1-year-old male was killed when a drunk driver struck the vehicle in which he was riding. The county CFRP panel recommended new legislation that would require stiff penalties in cases of vehicular manslaughter resulting from wantonly reckless behavior.

Community safety project:

A 3-year-old boy was playing with a cigarette lighter when a fire started in the bedroom. Smoke detectors were not present. In response to this fatality, the fire department canvassed the neighborhood with smoke detectors and sent messages through the media on fire prevention.

A 9-year-old girl was killed in a car accident when the vehicle she was riding in went off the road and down a steep embankment. While discussing this death, the local panel discovered that this dangerous stretch of road in southeast Missouri had been the scene of many deaths over the years. They responded with a letter to the Missouri Department of Transportation, requesting that a guardrail be constructed along the road.

Public forums:

A 7-month-old infant girl was asleep with her parents in their adult size bed. They awakened to find the child unresponsive. She had died from an accidental overlay. The southwest county CFRP panel flooded the community with educational materials about safe sleep arrangements and proper bedding for infants.

Educational activities in schools:

A 17-year-old male was killed in an alcohol-related crash on a rural road. Excessive speed and lack of seat belt use contributed to the death. The central Missouri CFRP panel responded to this tragic event by displaying the wrecked vehicle at the high school.

A 16-year-old female was killed in a motor vehicle crash while racing her car at excessive speeds; she was not wearing a seat belt. The panel and other area officials requested the Missouri State Highway Patrol bring the "Stop the Knock," a public awareness program to the area schools. Parents and teachers were invited to attend with the students.

Educational activities in the media:

A 3-year-old boy was left in a vehicle on an extremely hot day; he died of hyperthermia. The local CFRP panel arranged for area newspapers to publish warnings about the dangers involved in leaving children unattended in vehicles.

Consumer product safety:

A 3-year-old girl drowned in a pool after becoming trapped under a large flotation device. Although she was wearing a flotation vest at the time, it was not designed to hold a child's face above water. The panel contacted the Consumer Product Safety Action to report the problem with the flotation device.

News services:

An 8-month-old female was found unresponsive in her crib. She had been placed on her stomach and covered with a blanket. In their discussion, the CFRP panel noticed that this infant death was one of several in their community involving soft bedding and unsafe sleep arrangements. In an effort to prevent further deaths, the county panel flooded the news media with "back to sleep" materials and information on safe bedding practices for infants.

An 8-month-old female was placed in her parents' bed to sleep. A short time later, she was found unresponsive, wedged between the mattress and the wall. After the death, the local panel canvassed the neighborhood and surrounding area with safe sleep brochures. They provided local newspapers with safe sleep information that was published as a public service.

A 3-year-old boy was sent out to play with other neighborhood children on a very warm summer day. Some time later he was found dead in an abandoned car. The young child had apparently become locked in and died of hyperthermia. The local panel went to the local newspaper and other media sources to warn the community about the dangers young children face when they are not supervised adequately.

Changes in agency practice:

An 11-month-old male died after being accidentally over medicated by hospital staff. The local CFRP panel met with hospital staff to review medication labeling and administering procedures.

A 3-year-old male was struck in the head by his father and died. The family had an extensive history of domestic violence and other problems. The panel suggested to the local hospitals that when treating an adult victim for domestic violence, children should also be evaluated for abuse and neglect.

A 4-month-old infant boy died after being struck in the head by his unlicensed child care provider. The childcare provider had previously been brought to the attention of the prosecuting attorney's office for being unlicensed with too many children in her care. The panel responded by sending a letter to the prosecutor expressing their concern about the apparent lack of response and requesting that licensing regulations be enforced.

Other programs/activities:

A 2-month-old infant girl was sleeping with her parent on a couch, where she died as a result of accidental suffocation due to overlay. The local CFRP panel went to the area hospital to ensure that parents would be warned of the dangers of co-sleeping before taking their newborn home. They also gave the hospitals "Safe Sleep" brochures to hand out.

A 10-month-old female died when the vehicle she was riding in was rear-ended at an intersection. The safety seat she was riding in was not the appropriate size for a small infant and the child strangled on the harness strap. The CFRP panel talked with hospital staff and parents will now be advised on the proper size and use of safety seats.

A 6-day-old male infant was found unresponsive in his parent's bed. The local panel suggested that the county health department provide more education to new parents on safe sleep for infants. They also arranged for grief support for the parents.